

***Federal Fiscal Year 2001  
FRAMEWORK FOR ANNUAL REPORT  
OF STATE CHILDREN'S HEALTH INSURANCE PLANS  
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT***

**Preamble**

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- ❖ Recognize the *diversity* of State approaches to SCHIP and allow States *flexibility* to highlight key accomplishments and progress of their SCHIP programs, **AND**
- ❖ Provide *consistency* across States in the structure, content, and format of the report, **AND**
- ❖ Build on data *already collected* by CMS quarterly enrollment and expenditure reports, **AND**
- ❖ Enhance *accessibility* of information to stakeholders on the achievements under Title XXI.

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OF STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER  
TITLE XXI OF THE SOCIAL SECURITY ACT***

State/Territory: State of Indiana  
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

\_\_\_\_\_  
(Signature of Agency Head)

SCHIP Program Name(s): Hoosier Healthwise for Children

SCHIP Program Type:  
☐ Medicaid SCHIP Expansion Only  
☐ Separate SCHIP Program Only  
☒ Combination of the above

Reporting Period: Federal Fiscal Year 2001 (10/1/2000-9/30/2001)

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Submission Date: \_\_\_\_\_

*(Due to your CMS Regional Contact and Central Office Project Officer by January 1, 2002) Please cc Cynthia Pernice at NASHP (cpernice@nashp.org)*

## SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

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*This sections has been designed to allow you to report on your SCHIP program changes and progress during Federal fiscal year 2001 (September 30, 2000 to October 1, 2001).*

### **1.1 Please explain changes your State has made in your SCHIP program since September 30, 2000 in the following areas and explain the reason(s) the changes were implemented.**

*Note: If no new policies or procedures have been implemented since September 30, 2000, please enter "NC" for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.*

- A. Program eligibility-NC
- B. Enrollment process-NC
- C. Presumptive eligibility-NC
- D. Continuous eligibility-NC
- E. Outreach/marketing campaigns – During FFY 2001, Hoosier Healthwise coordinated with local schools to help increase enrollment levels for children that are in the free or reduced lunch programs. Updated brochures were printed to attract teens and older children.
- F. Eligibility determination process-NC
- G. Eligibility redetermination process-NC
- H. Benefit structure-NC (See Attachment A: CHIP Benefit Package)
- I. Cost-sharing policies-NC
- J. Crowd-out policies-NC
- K. Delivery system-The majority of Hoosier Healthwise members are in one of our Managed Care Organizations. There are currently 3 MCOs throughout Indiana's 92 counties: MDWise, Managed Health Services and Harmony Health Plan. Maxicare, another Indiana MCO, went out of business during FFY 2001. There is also a plan currently under way to implement mandatory MCO membership to take effect in six Indiana counties to begin the next Fiscal year.
- L. Coordination with other programs (especially private insurance and Medicaid)-NC
- M. Screen and enroll process-NC
- N. Application-NC
- O. Other-NC

**1.2 Please report how much progress has been made during FFY 2001 in reducing the number of uncovered low-income children.**

- A. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2001. Describe the data source and method used to derive this information.

CPS data were originally used to estimate the baseline number of uninsured children. The three-year average of 1996, 1997, and 1998 CPS data suggested that there were 123,000 children in Indiana under 200% of the federal poverty level.

However, as of September 2001, more than 190,000 children have enrolled in Hoosier Healthwise since May 31, 1998, when outreach for the Medicaid Expansion of SCHIP began. Therefore, we have enrolled more than 67,000 uninsured children above the original estimate.

In response, the State commissioned a survey of the uninsured in Indiana in order to establish a better estimate of the number of uninsured children below 200% of the federal poverty level. The survey was complete as of June 2000 and indicated that 57,000 children below 200% of the federal poverty remained uninsured. By adding these remaining uninsured children to the number of children already enrolled into the program as of June 2000(128,386), we calculate a revised original estimated of 185,386. This reflects an adjusted maximum estimate of the original baseline number of uninsured children in Indiana. The new baseline is 57,000 uninsured children as of June 2000. Hoosier Healthwise enrollment figures are based on unduplicated, point-in-time counts on the last day of each month from Indiana's Client Eligibility System (ICES).

- B. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

As of September 30, 2001 there were 400,500 children enrolled in Hoosier Healthwise- Indiana's health insurance program for children, pregnant women, and low-income families. This represents an increase of over 190,000 children since the Title XXI outreach efforts across the State began in May 1998 of whom 142,500 of these children are eligible through Medicaid. Hoosier Healthwise enrollment figures are based on unduplicated, point-in-time counts on the last day of each month from Indiana's Client Eligibility System (ICES).

- C. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

In FFY 2000, Indiana commissioned a survey of 10,000 households across the state to collect insurance information on individuals under age 65, using Census estimates for 1999. This update allowed for a more accurate representation regarding the number of uninsured compared to Indiana's population as a whole. (See Attachment B: Indiana Health Insurance Survey). At this time, a new survey is not being planned to learn the most recent rate of uninsured Hoosiers, however we hope to apply the results of this survey to 2000 Census data once it becomes available in divided age groups.

- D. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

☒ No, skip to 1.3

☐ Yes, what is the new baseline?

A. What are the data source(s) and methodology used to make this estimate?

N/A

B. What was the justification for adopting a different methodology?

N/A

C. What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

N/A

D. Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

N/A

**1.3 Complete Table 1.3 to show what progress has been made during FFY 2001 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).**

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

- |           |  |
|-----------|--|
| Column 1: | List your State's strategic objectives for your SCHIP program, as specified in your State Plan.  |
| Column 2: | List the performance goals for each strategic objective.   |
| Column 3: | For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary. |

*Note: If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter "NC" (for no change) in column 3.*

<b>Table 1.3</b> (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
<b>Objectives related to Reducing the Number of Uninsured Children</b>		
Uninsured, targeted low-income children will have health insurance as a result of Indiana's Title XXI program.	The CPS conducted in 1999 will show a 10% reduction in the percentage of targeted low-income children who do not have health insurance coverage over the findings of the 1998 results.	NC
<b>Objectives Related to SCHIP Enrollment</b>		
Uninsured, targeted low-income children will have health insurance through Indiana's Title XXI program.	By September 30, 1999, 40,000 previously uninsured, targeted low-income children will have health insurance through Title XXI.	<p>Data Sources: IndianaAIM (Medicaid Management Information System)</p> <p>Methodology: Based on combined unduplicated count for October 1, 2000 through September 30, 2001.</p> <p>Progress Summary: There were 71,171 children who obtained health insurance through Indiana's Medicaid expansion portion of the Title XXI program at some point between October 1, 2000 and September 30, 2001. Of these, there were 57,223 children enrolled in the program on September 30, 2001. This represents a 13% increase from September 30, 2000. There were 9,027 children who obtained health insurance through Indiana's State-designed program at some point between October 1, 2000 and September 30, 2001. Of these, there were 8,618 children enrolled in the program on September 30, 2001. This represents a 54% increase from September 30, 2000.</p>
<b>Objectives Related to Increasing Medicaid Enrollment</b>		
Children currently eligible but not enrolled in Medicaid will be identified and enrolled in that program.	By September 30, 1999, there will be at least a 10% increase in Title XIX Medicaid enrollment of children under age 19.	<p>Data Sources: NC</p> <p>Methodology: NC</p> <p>Progress Summary: As of September 30, 1999, Title XIX Medicaid enrollment of children under age 19 had increased 38.9% since May 31, 1998. As of September 30, 2001, Title XIX Medicaid enrollment of children under age 19 had increased 48.4% since May 31, 1998.</p>
<b>Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)</b>		
Children enrolled in Indiana's Title XXI program will have a consistent source of medical and dental care.	By September 30, 1999, 95% of children enrolled in Title XXI will self-select their primary medical provider.	<p>Data Sources: IndianaAIM (Medicaid Management Information System)</p> <p>Methodology: Comparison of default auto-assignment rates for September 1999 and September 2001 for all Hoosier Healthwise children as well as Title XXI-specific enrollees.</p> <p>Progress Summary: In September 2001, 4.3% of Hoosier Healthwise members (Title XIX and XXI) were auto-assigned to a PMP compared to 8.2% in September 1999. In September 2001, 5.3% of Title XXI children were auto-assigned to a PMP compared to 7.0% in September 2000 (used as the basis of comparison since a portion of the Title XXI program was not implemented until January 2000).</p>

<b>Table 1.3</b> (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
<b>Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)</b>		
Children enrolled in Hoosier Healthwise will enjoy improved health status.	By September 30, 1999, measures of health status in place for Hoosier Healthwise will show improvements in the immunization of 2-year olds and preventive health.	Data Sources: NC  Methodology: NC  Progress Summary: No change in this performance goal. However, additional information on well-child visits for Title XXI children is included in the text immediately following this chart.
<b>Other Objectives</b>		
Parents/children enrolled in Title XXI will be satisfied with the program.	At least 75% of parents surveyed during the first year of their child's participation in the program will express overall satisfaction with the Title XXI program.	Data Sources: 1998, 2000 and 2001 Hoosier Healthwise Member Satisfaction Surveys  Methodology: <u>Surveys from all years:</u> A random sample of Hoosier Healthwise members were selected from throughout Indiana. The surveys were conducted in either a one-on-one telephone or in-person interview in which each question was read exactly as worded. Responses were recorded and sent to an independent market research organization for data analysis. The survey used two questionnaires: one for the adult population and one for the child population.  <u>1998 Survey:</u> A random sample of 1,505 Hoosier Healthwise members enrolled in September 1998 who had been in the program at least six months.  <u>2000 Survey:</u> A random sample of 1,430 Hoosier Healthwise members enrolled in September 1999 who had been in the program at least six months.  <u>2001 Survey:</u> A random sample of 1,592 Hoosier Healthwise members enrolled in September 2000 who had been in the program at least six months.  Progress Summary: Surveys from both years include children enrolled in Title XIX and in Title XXI. We were unable to obtain Title XXI-specific data. Members rating the Hoosier Healthwise program very good or good (using a five-point scale) in the 1998 survey were 86% of all members surveyed; in 2000, 84% of all members surveyed; and in 2001, 86% of all members surveyed. In 2001, the number of members rating the program "very good" was its highest level to date at 52% of all members surveyed.

**Objective 1: Uninsured, targeted low-income children will have health insurance as a result of Indiana's Title XXI program.**

Indiana has used different methodologies to try to best identify the number of children in the state without health insurance. We continue to enroll more children than our estimates predict actually need health

insurance. In last year's report, we adjusted the methodology to enlarge the sample size in the CPS data. We did this by aggregating one set of three years' worth of data (1996-1998) and compared this to a second set of three years' worth of data (1997-1999). In both sets of data, duplicate individuals were removed. This new calculation showed an 11.1% decrease in the percentage of targeted low-income children that were uninsured. The actual number of children estimated by CPS in 1999 that were uninsured and under 200% of FPL was 88,497. When more revised census data stemming from the results of the 2000 census becomes available, we will update our forecast.

**Objective 2: Uninsured, targeted low-income children will have health insurance through Indiana's Title XXI program.**

Indiana reported that it exceeded the Title XXI enrollment goal of 40,000 previously uninsured, targeted low-income children on the March, 2000 evaluation. Since that time period, we have exceeded our State Plan goal with 82,381 children receiving health insurance through Indiana's Title XXI program at some point in FFY00 and 71,171 receiving health insurance at some point in FFY01. This figure includes children who became eligible for Hoosier Healthwise as a result of the 1997 Medicaid expansion to children born before October 1, 1983 with family incomes of no more than 100 percent of the federal poverty level, children who became eligible due to the 1998 expansion of family income up to 150 percent of the federal poverty level, and children who became eligible through the state-only program in January 2000 with expansion of family income up to 200 percent of the federal poverty level. Despite the fact that older children in Hoosier Healthwise "age out" of the program, Indiana still saw a 13% increase in the Title XXI program from September 2000 to September 2001 and continues to exceed its target of 40,000 with 57,223 children enrolled in the program as of September 30, 2001.

**Objective 3: Children currently eligible but not enrolled in Medicaid will be identified and enrolled in that program.**

We reported in our March, 2000 evaluation that Indiana far exceeded its goal of increasing Title XIX enrollment for children under age 19. Since last March, we have sustained and, in fact, seen increases in enrollment in this program for children under age 19.

**Objective 4: Children enrolled in Indiana's Title XXI program will have a consistent source of medical and dental care.**

Our auto-assignment rates for the Hoosier Healthwise program as a whole and for the Title XXI program specifically are continuing to decrease over time. All children enrolled in Hoosier Healthwise select or are assigned to a primary medical provider (PMP) unless the child is a ward of the State, resides in an institution, requires certain level of care, or lives in a medically underserved area that does not have a provider available to serve as the child's PMP. As we reported in our March 2000 evaluation, prior to the Title XXI Medicaid expansion (June 1998), 15 percent of Hoosier Healthwise members were auto-assigned to a PMP. This number has decreased significantly over the last three years to 4.3% in September 2001. For the Title XXI program specifically, the auto-assignment rate decreased from 7.0% in September 2000 to 5.3% in September 2001.

Indiana continues to target counties where the State wants to increase the number of PMPs serving members. As of September 1999, there were PMPs in all 92 counties in the State. As of August 2001, there were 2,091 PMPs enrolled in Hoosier Healthwise as compared to 1,941 in September 1999 and 1,832 in June 1998. We have also added two new managed care organizations as of January 2001.

**Objective 5: Children enrolled in Hoosier Healthwise will enjoy improved health status.**

We analyzed claims from the IndianaAIM (Medicaid Management Information System) to determine if our newest members to Hoosier Healthwise were receiving well-child care. Specifically, we analyzed children in the Title XXI Medicaid expansion program ages one to six (there is not enough

data available yet to analyze our state-designed program). The children included in our Medicaid expansion study are those in families with incomes between 100 and 150 percent of the federal poverty level. We analyzed claims to primary medical providers (PMPs) for those children in the program at least six months during the state fiscal year 2000 (between July 1, 1999 and June 30, 2000). Our data shows that for children age one, more than 80 percent had seen a PMP at least once during the state fiscal year. For children age two, 79 percent had seen a PMP at least once during the state fiscal year. For children at each age group between three and six, at least 60 percent had seen a PMP during the state fiscal year. An analysis was also conducted for the same time period for children in the Title XIX portion of Hoosier Healthwise. This population had even better indicators of well-child care occurring. When we studied the same age groups in Title XIX, for children age one, more than 91 percent had seen a PMP during the state fiscal year. For children age two, the percentage was 83 percent. For children at each age group between three and six, the percentage was at least 72 percent. We will continue to monitor well-child visits for this population as well as the children in our state-designed program as both programs mature.

**1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.**

Nearly all of our performance goals were met in the FFY 2001 report. This year, the only performance goal not met is for Objective 4, “Children enrolled in Indiana’s Title XXI program will have a consistent source of medical and dental care.” The performance goal was that 95% of children enrolled in Title XXI will self-select their primary medical provider. However, the goal was almost achieved, with 94.7% selecting their own physician. This is an improvement over the previous year, which was still close to the goal at 92.9%.

**1.5.1 Discuss your State’s progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.**

N/A

**1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.**

N/A

**1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program’s performance. Please list attachments here.**

Attachment C: Member Satisfaction Survey  
Attachment D: Provider Satisfaction Survey  
Attachment E: 4 Steps to CHIP Success

## SECTION 2. AREAS OF SPECIAL INTEREST

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*This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.*

### 2.1 Family coverage:

- A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

N/A

- B. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2001 (10/1/00 - 9/30/01)?

N/A Number of adults

N/A Number of children

- C. How do you monitor cost-effectiveness of family coverage?

N/A

### 2.2 Employer-sponsored insurance buy-in:

- A. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

N/A

- B. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2001?

N/A Number of adults

N/A Number of children

### 2.3 Crowd-out:

- A. How do you define crowd-out in your SCHIP program?

Crowd out is defined as the entry of applicants into the CHIP program who are eligible for and have access to other (commercial) insurance.

- B. How do you monitor and measure whether crowd-out is occurring?

Crowd-out is monitored by the number of children with commercial health insurance who apply for Hoosier Healthwise. Applicants are required to indicate on the application whether or not they have commercial health insurance. Children who have commercial health insurance may be eligible for Title XIX Medicaid, but will not be considered for the Title XXI program. Children must be without commercial health insurance for three months before they can be determined eligible for CHIP, unless the loss of private coverage is not voluntary (i.e. loss of job, employer drops family coverage). Crowd-out is measured by the percentage of children with commercial health insurance who have applied for Hoosier Healthwise.

- C. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

Indiana does not specifically track crowd out data on Title XXI children. Since the implementation of Title XXI in May of 1998, there has not been a major change of children who have other creditable health insurance; of total Hoosier Healthwise members, 12.9% had other insurance in September 9.5% in September 2001. This however, would not necessarily be problematic to the Hoosier Healthwise program, since members in Title XIX are allowed other insurance.

- D. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

The most effective deterrent appears to be the implementation of the three-month waiting period between private coverage and enrollment into Hoosier Healthwise. Parents are not willing to go without insurance for their children if they are already covered by another source, and so we are effectively covering just those who do not have insurance. Crowd-out has not appeared to have any countable effect on enrollment in Hoosier Healthwise.

## **2.4 Outreach:**

- A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

Successful methods of reaching low-income, uninsured children during FFY 2001 included:

- Local enrollment initiatives were pursued by the 92 county offices of the Division of Family and Children (DFC), including booths at health and county fairs;
- Alternative enrollment options such as mail-in applications and more than 500 enrollment centers throughout the state remained popular alternatives to the local DFC office.
- The state began the third year in a three-year Robert Wood Johnson (RWJ) Covering Kids outreach grant targeting hard-to-reach populations. Eight local coalitions are implementing projects to identify and serve the hardest-to-serve populations. The Covering Kids coalitions have found that creating partnerships with community organizations has led to outreach success. Through partnerships, more community organizations are made aware of Hoosier Healthwise and can refer uninsured families to an enrollment center or to the local DFC; and
- CHIP has worked with the Indiana Department of Education to reach children who are enrolled in the Free and Reduced Meal Program. Public schools, parochial schools, and childcare centers participated in this project. CHIP has participated in this collaboration in past years, but this year attempted to improve and streamline the process. Schools sent electronic lists of families who applied for the meal program to FSSA. Families who were not already enrolled in the program were mailed an information packet, which included an application.

Effectiveness has been measured in accordance with the number of children who have enrolled. Hoosier Healthwise enrollment has increased by more than 190,000 children since May 1998. This increase is the clearest evidence that the outreach succeeded in bringing more eligible children into Hoosier Healthwise.

Our Hoosier Helpline assists in measuring successful outreach strategies by asking callers how they learned of Hoosier Healthwise. For FFY 2001, one-fourth (24%) said they had heard of Hoosier Healthwise from a friend, and 9% heard of the program from the brochures. Seven percent of the callers learned of Hoosier Healthwise through school, which could indicate that collaborating with the

Free and Reduced Meal Program is already working. There were a variety of other sources which explained the program to potential members such as the internet, health fairs, or clinics.

- B. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

Teenagers continue to be a hard-to-reach population. A recent statewide survey showed that a large percentage of teenagers were uninsured but eligible for Hoosier Healthwise. Indiana has attempted to make teenagers and their parents more aware of Hoosier Healthwise by redesigning informational brochures. The previous brochure contained photos of young children who were under the age of 12. However, the new brochure includes photos of teens on the front cover, and was rewritten to specifically mention on teenagers. These modifications have been made in recent months, and there have been no noticeable changes as of yet. This may change over time.

Local community organizations are often a source of information for underserved communities. Many local DFC offices and Covering Kids projects have distributed information to local organizations and have enlisted their help in outreach efforts.

<i>Demographic Indicator</i>	<i>2000 Census (Adults and Children)</i>	<i>Medicaid</i>	<i>CHIP Medicaid Expansion (up to 150% FPL)</i>	<i>CHIP State-only Program (up to 200% FPL)</i>
White, Not Hispanic/Latino	85.8%	63.8%	74.5%	80.3%
Black or African American	8.4%	27.7%	18.1%	12.8%
Asian	1.0%	0.3%	0.3%	0.5%
American Indian or Native Alaskan	0.3%	0.1%	0.0%	0.0%
Hispanic or Latino	3.5%	7.1%	6.1%	5.1%
Other	1.0%	1.1%	0.9%	1.2%

Demographic data obtained from IndianaAIM

- C. Which methods best reached which populations? How have you measured effectiveness?

The State of Indiana believes that a multi-faceted approach is critical to reaching families through community outreach and supporting one of the most valuable approaches to enrolling families, which is through word-of-mouth. The Hoosier Healthwise enrollment increase is the clearest evidence that outreach efforts have been successful.

## 2.5 Retention:

- A. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?
- B. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?
- ☒ Follow-up by caseworkers/outreach workers
  - ☒ Renewal reminder notices to all families
  - ☐ Targeted mailing to selected populations, specify population
  - ☐ Information campaigns
  - ☐ Simplification of re-enrollment process, please describe

\_\_\_\_ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe  
\_\_\_\_ Other, please explain

C. Are the same measures being used in Medicaid as well? If not, please describe the differences.

Yes, the reenrollment process is the same for both the Medicaid and SCHIP enrollees.

D. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

Indiana continues to monitor and encourage Hoosier Healthwise members to remain in the program as long as they are eligible. Through the efforts previously described, we have tracked new members in the program to see that they remain in the program and are receiving services. We studied new members in our two CHIP programs to determine their “tenure” in the program.

- For our CHIP program that was based on SCHIP-Medicaid expansion, we studied new members who enrolled in SFY99 and found that after a two-year period, 66% either had no lapse in eligibility or a lapse but a subsequent return to the program.
- We then studied another group of members that enrolled in the Medicaid expansion program in SFY00. After a two-year period, 73% of these members either had no lapse in eligibility or a lapse but a subsequent return to the program.
- When we studied members that enrolled in the state-only CHIP program in SFY00, we found that 74% of these members either had no lapse in eligibility or a lapse but a subsequent return.

These results, when compared to comparable groups of members in Medicaid, yield similar outcomes. Furthermore, as our provider network and managed care options grow, we are finding improvements on member retention.

Other factors may also share responsibility for high reenrollment levels, such as the availability of PMPs and satisfaction levels with the program. (See Attachment F: *Independent Evaluation of Indiana’s CHIP*)

E. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage)?

At this time, we do not collect this type of information upon disenrollment.

## **2.6 Coordination between SCHIP and Medicaid:**

- A. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

Yes, SCHIP was built upon the existing infrastructure of the Medicaid program and therefore uses the same application and procedures. We have found this to be of the utmost usefulness since families in this income range fluctuate between the two programs. As a result, children in Indiana always have coverage, regardless of the program from which they are funded. (See Attachment G: Application for Hoosier Healthwise)

- B. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

When a child's eligibility status changes, the Indiana Client Eligibility System (ICES) assigns a new eligibility code to that child. This file is updated daily and therefore updates with other interfacing systems seamlessly. By building the SCHIP program upon the existing infrastructure of Medicaid, we eliminated any pitfalls that would occur when a child moves between the two programs.

- C. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

As mentioned above, CHIP is based on the same infrastructure as Medicaid. As a result, in order to be a provider for SCHIP, one must also agree to provide coverage to Medicaid eligibles, and vice versa. This has been an essential part of our success in keeping children enrolled as their family income changes.

## **2.7 Cost Sharing:**

- A. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

At this time, there has been no formal assessment of premium fees on participation of the State-Designed program. However, Indiana offers members the option to pay the premiums monthly, quarterly, or annually and we have been encouraged by the number of members who pay the premiums annually. This is an indication that the premium amount may not be a barrier to enrollment. For FFY 2001, 17% of families paid annually, 35% paid quarterly, and the remaining 48% paid their premiums every month. (See Attachment H: CHIP Cost-Sharing Requirements)

- B. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

There has not been any formal evaluation of the cost-sharing on utilization yet. However, co-payments are minimal and are only on ambulance transportation and prescription drugs, so the effect is likely to be negligible.

## **2.8 Assessment and Monitoring of Quality of Care:**

- A. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

Complaints and grievances are logged for calendar year 2000 through our Hoosier Healthwise Helpline to track member satisfaction with their doctors and Managed Care Organizations (MCOs). Information on quality of care is also obtained through provider and member satisfaction surveys. Findings from both of these collection methods are presented in the annual independent evaluation presented to the legislature. A

review of member helpline calls during calendar year 2000 found that only around 2% of helpline calls were quality related.

The MCOs are using HEDIS to measure quality of care received by our members. This data is divided by calendar year, rather than fiscal year. Unfortunately, the 2001 data is unavailable at this time.

- B. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

HEDIS reports were utilized to monitor the well-baby care, well-child care and immunizations by PCCM (Primary Care Case Management) doctors only. These reports also include prenatal care, and outpatient drug utilization. Reports were not available at this time by the remaining MCOs.

Indiana is also continuing use of member satisfaction and primary care provider satisfaction surveys.

- C. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

Indiana has continued its contract with EP&P Consulting, Inc. to perform another independent performance evaluation to be presented to the state legislature in April 2002.

## SECTION 3. SUCCESSES AND BARRIERS

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*This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.*

### **3.1 Please highlight successes and barriers you encountered during FFY 2001 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.**

*Note: If there is nothing to highlight as a success or barrier, Please enter “NA” for not applicable.*

- A. Eligibility- Currently, there is still low enrollment of eligible teenagers. However, with the new redesigned brochures aimed at including teens, there is hope that enrollment will increase for FFY 2002.
- B & C. Outreach/Enrollment – Changing the perception and de-stigmatizing Medicaid/CHIP is still a priority. All outreach efforts focus on affordable insurance similar to commercial plans, with little or no reference to traditional Medicaid programs. Enrollment forms are also kept simple, and families have over 500 different locations within the state which to apply.
- D. Retention/disenrollment-Children are automatically enrolled for 12 months once they are deemed eligible. The simplified renewal process and proactive attempt of caseworkers to inform the members that they need to reenroll are likely to keep eligible children enrolled beyond their first 12 months.
- E. Benefit structure- There have been no changes in Hoosier Healthwise’s rich benefit structure. Members still have access to not only medical, dental, and vision, but also chiropractic and foot care.
- F. Cost-sharing – Although some might argue that families want to pay premiums, it is impossible to determine with our current information if the monthly premium payments are a barrier for families who would otherwise remain enrolled. Although it can be determined how many disenroll, there is no information available to determine if cost is a factor.
- G. Delivery system – Because the two programs run together, families in Hoosier Healthwise can move between Medicaid and CHIP seamlessly and not run the risk of losing coverage during the transition. Mandatory managed care is being implemented for the Hoosier Healthwise members, to begin with a select number of counties in FFY 2002.
- H. Coordination with other programs –There are other programs in Indiana that seem to be a natural fit to CHIP in helping Hoosier children. One example of coordination efforts with other programs includes the First Steps program, which provides special care for children with developmental disabilities; and Children’s Special Health Care Services, which assists children with special needs. These programs serve as a wrap around to CHIP for special needs children. The participating MCOs also have special programs for its members, such as Start Smart, a prenatal care program.
- I. Crowd-out-The three month waiting period is a barrier for parents to enroll their children in Hoosier Healthwise who already have commercial insurance. This may be especially hard on farm families, who must keep catastrophic insurance because, in case of an accident or major medical problem, they would lose their farm. On the other hand, sometimes they cannot afford any preventative care for their children.
- J. Other-NA

## SECTION 4: PROGRAM FINANCING

*This section has been designed to collect program costs and anticipated expenditures.*

- 4.1 **Please complete Table 4.1 to provide your budget for FFY 2001, your current fiscal year budget, and FFY 2002-projected budget. Please describe in narrative any details of your planned use of funds.**

*Note: Federal Fiscal Year 2001 starts 10/1/00 and ends 9/30/01).*

	Federal Fiscal Year 2001 costs	Federal Fiscal Year 2002	Federal Fiscal Year 2003
<b>Benefit Costs</b>			
Insurance payments			
Managed care	4,576,297	4,950,000	5,700,000
per member/per month rate X # of eligibles			
Fee for Service	71,085,861	74,250,000	81,300,000
Total Benefit Costs	75,662,158	79,200,000	87,000,000
(Offsetting beneficiary cost sharing payments)	(839,586)	(880,000)	(970,000)
Net Benefit Costs	74,822,572	78,320,000	86,030,000
<b>Administration Costs</b>			
Personnel	267,372	286,000	286,000
General administration	3,588,785	3,474,000	3,914,000
Contractors/Brokers (e.g., enrollment contractors)	317,100	320,000	350,000
Claims Processing	1,026,000	720,000	750,000
Outreach/marketing costs	-	-	-
Other	481,361	500,000	500,000
Total Administration Costs	5,680,618	5,300,000	5,800,000
10% Administrative Cost Ceiling			
Federal Share (multiplied by enhanced FMAP rate)	4,171,278	3,887,020	4,253,720
State Share	1,509,340	1,412,980	1,546,280
<b>TOTAL PROGRAM COSTS</b>	<b>80,503,190</b>	<b>83,620,000</b>	<b>91,830,000</b>

**4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2001.**  
N/A

**4.3 What were the non-Federal sources of funds spent on your SCHIP program during FFY 2001?**

- ☒ State appropriations – TOBACCO SETTLEMENT FUNDS
- ☐ County/local funds
- ☐ Employer contributions
- ☐ Foundation grants
- ☐ Private donations (such as United Way, sponsorship)
- ☐ Other (specify)

**A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.**

No. The appropriation from the State is determined every two years through the biennium budget set by the Legislature. The Legislature set 2002 and 2003 appropriation for CHIP during the last session.

## SECTION 5: SCHIP PROGRAM AT-A-GLANCE

*This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.*

- 5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information.** If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Program Name	Hoosier Healthwise – Package A	Hoosier Healthwise -- Package C Children's Health Plan
Provides presumptive eligibility for children	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?
Provides retroactive eligibility	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, for whom and how long? <i>Benefits are retroactive up to 3 months for those who are determined to be eligible.</i>	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, for whom and how long? <i>Benefits are retroactive back to the first day of the month of application, once the first premium has been paid.</i>
Makes eligibility determination	<input checked="" type="checkbox"/> State Medicaid eligibility staff <input type="checkbox"/> Contractor <input type="checkbox"/> Community-based organizations <input type="checkbox"/> Insurance agents <input type="checkbox"/> MCO staff <input type="checkbox"/> Other (specify)	<input checked="" type="checkbox"/> State Medicaid eligibility staff <input type="checkbox"/> Contractor <input type="checkbox"/> Community-based organizations <input type="checkbox"/> Insurance agents <input type="checkbox"/> MCO staff <input type="checkbox"/> Other (specify)
Average length of stay on program	Specify months <u>9.9</u>	Specify months <u>10.3</u>
Has joint application for Medicaid and SCHIP	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
Has a mail-in application	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
Can apply for program over phone	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
Can apply for program over internet	<input checked="" type="checkbox"/> No (However, can be downloaded or printed off of CHIP website) <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Requires face-to-face interview during initial application	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, specify number of months What exemptions do you provide?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, specify number of months <u>3 months</u> What exemptions do you provide? <i>An exemption is provided if the family has an involuntary loss of coverage (loss of job, etc) or if the child was previously covered by Medicaid.</i>

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Provides period of continuous coverage <u>regardless of income changes</u>	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, specify number of months <u>12</u> Explain circumstances when a child would lose eligibility during the time period. <i>A child would lose eligibility if he/she moved out of state, or turned age 19.</i>	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, specify number of months <u>12</u> Explain circumstances when a child would lose eligibility during the time period <i>A child would lose eligibility if the premium is not paid, if the child moves out of state, if the child is included under a private insurance plan that is considered creditable, or if the child turned age 19 during the year</i>
Imposes premiums or enrollment fees	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, how much? Who Can Pay? <input type="checkbox"/> Employer <input type="checkbox"/> Family <input type="checkbox"/> Absent parent <input type="checkbox"/> Private donations/sponsorship <input type="checkbox"/> Other (specify)	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, how much? Who Can Pay? <input type="checkbox"/> Employer <input checked="" type="checkbox"/> Family <input type="checkbox"/> Absent parent <input type="checkbox"/> Private donations/sponsorship <input checked="" type="checkbox"/> Other (specify) <u>Guardian</u>
Imposes copayments or coinsurance	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
Provides preprinted redetermination process	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, we send out form to family with their information precompleted and: <input type="checkbox"/> ask for a signed confirmation that information is still correct <input type="checkbox"/> do not request response unless income or other circumstances have changed	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, we send out form to family with their information and: <input type="checkbox"/> ask for a signed confirmation that information is still correct <input type="checkbox"/> do not request response unless income or other circumstances have changed

## 5.2 Please explain how the redetermination process differs from the initial application process.

A letter is sent to the family, reminding them that their twelve-month enrollment period is over and they must reenroll to stay in the program. See Attachment I: A sample letter of redetermination to families.

## SECTION 6: INCOME ELIGIBILITY

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*This section is designed to capture income eligibility information for your SCHIP program.*

- 6.1 As of September 30, 2001, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group?** If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

**Title XIX Child Poverty-related Groups or  
Section 1931-whichever category is higher**

150% of FPL for children under age 1  
133% of FPL for children aged 1 through 5  
100% of FPL for children aged 6 through 18

**Medicaid SCHIP Expansion**

150% of FPL for children aged 1 through 18  
       % of FPL for children aged         
       % of FPL for children aged       

**Separate SCHIP Program**

200% of FPL for children aged 1 through 18  
       % of FPL for children aged         
       % of FPL for children aged       

- 6.2 As of September 30, 2001, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income?** *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA".*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination)

       Yes   X   No

If yes, please report rules for applicants (initial enrollment).

<b>Table 6.2</b>			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	Separate SCHIP Program
Earnings	\$90	\$90	\$90
Self-employment expenses	40% of gross income	40% of gross income	40% of gross income
Alimony payments Received	\$0	\$0	\$0
Paid	\$0	\$0	\$0
Child support payments Received	\$50	\$50	\$50
Paid	\$0	\$0	\$0
Child care expenses	\$200 if child is under 2 years of age. \$175 if child is 2 years of age or older	\$200 if child is under 2 years of age. \$175 if child is 2 years of age or older	\$200 if child is under 2 years of age. \$175 if child is 2 years of age or older
Medical care expenses	\$0	\$0	\$0
Gifts	\$0	\$0	\$0
Other types of disregards/deductions (specify)	\$0	\$0	\$0

### 6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups

☒ No ☐ Yes, specify countable or allowable level of asset test \_\_\_\_\_

Medicaid SCHIP Expansion program

☒ No ☐ Yes, specify countable or allowable level of asset test \_\_\_\_\_

Separate SCHIP program

☒ No ☐ Yes, specify countable or allowable level of asset test \_\_\_\_\_

Other SCHIP program \_\_\_\_\_

☐ No ☐ Yes, specify countable or allowable level of asset test N/A

### 6.4 Have any of the eligibility rules changed since September 30, 2001?

☐ Yes ☒ No

## SECTION 7: FUTURE PROGRAM CHANGES

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*This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.*

**7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2002 (10/1/01 through 9/30/02)?** Please comment on why the changes are planned.

- A. Family coverage – The Health Insurance for Indiana Families (HIIF) Committee investigated strategies for extending health insurance coverage to uninsured Indiana citizens currently unable to join the State’s existing health insurance programs. During FFY 2001, Indiana SEA 561 passed and expanded Medicaid coverage to parents of children in Hoosier Healthwise, from 25% to 100% of the Federal Poverty Level. Medicaid is expanding to assist more uninsured adults.
- B. Employer sponsored insurance buy-in - There are no plans to incorporate employer sponsored insurance buy-in in CHIP at this time.
- C. 1115 waiver – We currently have a 1115 waiver under review by CMS called the “Windows of Opportunity” project to remove windows in homes of children in the Hoosier Healthwise program who have been lead poisoned. Another 1115 waiver was submitted to extend vision and dental coverage to children who have other health insurance. This waiver was mandated Indiana SEA 459.
- D. Eligibility including presumptive and continuous eligibility – At this time, Indiana does not plan to pursue presumptive or continuous eligibility (beyond the twelve month enrollment period).
- E. Outreach- There is a plan to continue with and expand the current collaboration with the Free or Reduced Price Meals Program so we can reach even more potentially eligible children through schools and child-care centers. We will continue to promote Hoosier Healthwise through outreach efforts of the DFCs and the Covering Kids Initiative.
- F. Enrollment/redetermination process-Now that CHIP has been in existence for a longer period of time, more data will be available for further study and possible tracking of enrollment and redetermination processes.
- G. Contracting- Currently in the transition with a new premium collection vendor. The State of Indiana is now contracting with Dental Health Administrative and Consulting Services, Inc. (DHACS) to collect premiums from our members.
- H. Other

